

<b>Case Number:</b>	CM13-0031217		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	01/10/2012
<b>Decision Date:</b>	08/01/2014	<b>UR Denial Date:</b>	09/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Nevada. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 56-year-old female who was reportedly injured on 1/10/2012. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated 7/11/2013, indicated that there were ongoing complaints of neck, right shoulder, right elbow, and bilateral wrist pains. The physical examination demonstrated cervical spine: Positive tenderness to palpation paraspinal muscles and range of motion with pain. Right shoulder: Well healed surgical scars, flexion 180, extension 40, abduction 90 adduction 30, internal rotation 55, and external rotation 50. Right wrist tenderness to palpation, flexion/extension 40. No recent diagnostic studies were available for review. Previous treatment included right shoulder arthroscopy, physical therapy, over-the-counter Tylenol, ibuprofen, Relafen and Prilosec. A request had been made for retrospective request for 16 electrodes pair (DOS: 7/25/13), retrospective request for 24 replacement batteries (DOS: 7/25/13), retrospective request for 32 adhesive remover wipes (DOS: 7/25/13) and was not certified in the pre-authorization process on 9/18/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**RETROSPECTIVE REQUEST FOR 16 ELECTRODES, PAIR (DOS: 7/25/13):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113-116 OF 127.

**Decision rationale:** Treatment guidelines support the use of a transcutaneous electrical nerve stimulation (TENS) unit in certain clinical settings of chronic pain, as a one month trial when used as an adjunct to a program of evidence-based functional restoration for certain conditions and for acute postoperative pain in the first 30 days following surgery. Based on the evidence-based trials, the injured worker is status post right shoulder arthroscopy December 2012. There was no support for the continued use of a TENS unit seven months status post-surgery as a primary treatment modality. The record reviewed was handwritten and only partially legible. It provided no documentation of an ongoing program of evidence-based functional restoration. In the absence of such documentation, this request does not meet guideline criteria for the continued use of a TENS unit and its components. Therefore, this request is deemed not medically necessary.

**RETROSPECTIVE REQUEST FOR 24 REPLACEMENT BATTERIES (DOS: 7/25/13):**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113-116 of 127.

**Decision rationale:** Treatment guidelines support the use of a transcutaneous electrical nerve stimulation (TENS) unit in certain clinical settings of chronic pain, as a one month trial when used as an adjunct to a program of evidence-based functional restoration for certain conditions, and for acute postoperative pain in the first 30 days following surgery. Based on the evidence-based trials, the injured worker is status post right shoulder arthroscopy December 2012. There was no support for the continued use of a TENS unit seven months status post-surgery as a primary treatment modality. The record reviewed was handwritten and only partially legible. It provided no documentation of an ongoing program of evidence-based functional restoration. In the absence of such documentation, this request does not meet guideline criteria for the continued use of a TENS unit and its components. Therefore, this request is deemed not medically necessary.

**RETROSPECTIVE REQUEST FOR 32 ADHESIVE REMOVER WIPES (DOS: 7/25/13):**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113-116 OF 127.

**Decision rationale:** Treatment guidelines support the use of a transcutaneous electrical nerve stimulation (TENS) unit in certain clinical settings of chronic pain, as a one-month trial when used as an adjunct to a program of evidence-based functional restoration for certain conditions, and for acute postoperative pain in the first 30 days following surgery. Based on the evidence-based trials, the injured worker is status post right shoulder arthroscopy December 2012. There was no support for the continued use of a TENS unit seven months status post-surgery as a primary treatment modality. The record, reviewed, was handwritten and only partially legible. It provided no documentation of an ongoing program of evidence-based functional restoration. In the absence of such documentation, this request does not meet guideline criteria for the continued use of a TENS unit and its components. Therefore, this request is deemed not medically necessary.